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'Do I cry or just carry on': A story completion study of healthcare professionals' anticipated responses to experiencing chest pain

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Abstract

Healthcare professionals may experience barriers to seeking healthcare that differ from the general population. We explored healthcare professionals' anticipated responses to experiencing chest pain following a period of stress using qualitative story completion method with healthcare professionals ($n = 44$). Data were analysed using reflexive thematic analysis, which identified three themes: "'Do I cry or just carry on?": A Culture of Suffering in Silence' identified worries that expressing health concerns would be perceived as weakness, with potential impact on career opportunities. Participants also described self-diagnosis and self-medication rather than help-seeking. "'Me? Have a panic attack?": Psychosomatic Shame' suggested mental health issues may be ignored due to stigma. "'We definitely don't take care of ourselves": Prioritising Pressures of Multiple Responsibilities over Self-care' identified real or perceived pressures to de-prioritise their health. Future research should explore the design of confidential, time efficient support for healthcare professionals that tackle cultural norms and barriers to self-care.

Keywords

health behaviour, health beliefs, healthcare professionals, NHS, qualitative, story completion

Introduction

Healthcare professionals play a key role in providing healthcare services to patients but also face their own challenges in relation to health and wellbeing. The prevalence of psychiatric morbidity amongst doctors has been found to be as high as 52% (17%–52% across 22 studies), with burnout reported between 31% and 54% (Imo, 2017). Similarly, the prevalence of burnout syndrome in paediatric intensive care unit nurses is reported between 42% and 77% (Matsuishi et al., 2021). These figures are unlikely to have improved following the additional stresses of the Covid-19 pandemic and associated ongoing workload implications (Harris et al., 2021).

Previous research suggests healthcare professionals are reluctant to seek medical help through usual channels such as GP visits (Gross et al., 2000) and report self-diagnosis, self-treatment (Rosvold and Bjertness, 2002),

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engaging in informal healthcare such as 'corridor conversations' (Kay et al., 2008), or neglecting symptoms to continue working (Onchonga et al., 2020). Reasons reported for not seeking help have included embarrassment, time and cost, personality factors, medical knowledge, and concerns about medical information being kept confidential. Previous qualitative research has also suggested general practitioners worry about being perceived as medically incompetent if they are unable to cope with their own physical symptoms (Thompson et al., 2001). The 'culture of carrying on' in healthcare has been highlighted by previous research (McKevitt et al., 1997; Thompson et al., 2001) with both implicit and explicit pressure to continue working through illness, and sick leave seen as putting a burden on colleagues. For mental health, doctors have reported barriers to help-seeking as a negative workplace culture, lack of openness around mental health in the workplace, expectations of doctors, and generational differences. Whilst they report facilitators to include positive perceptions towards help-seeking for mental health in self or others, access to an external confidential service, a belief that taking care of their mental health results in better patient outcomes, protected time, greater awareness and accessibility, open culture, and supportive supervisors (Zaman et al., 2022).

Whilst previous research has examined healthcare professionals' help seeking behaviours, the majority of studies have taken a quantitative approach, focused only on doctors rather than the wider multidisciplinary team (MDT) of healthcare professionals, and are either outdated or focused on the specific impact of providing care during Covid-19. Understanding healthcare professionals' response to illness and the barriers they face is an important step in identifying their support needs. This also has the potential to inform the design of support structures or interventions to promote positive health and wellbeing in healthcare professionals. Thus, the aim of this study is to explore healthcare professionals' anticipated responses to experiencing chest pain following a period of stress at work.

Methods

Story completion methodology was used to address the aim of this study. Story completion is a qualitative technique that involves presenting participants with a story 'stem' and asking them to finish the story (Clarke et al., 2017). Story completion methodology was chosen to aim to obtain detailed insights into implicit views participants may hold, that may not surface through other methods (Clarke et al., 2017). Some of the behaviours identified in the literature review (such as self-treatment or self-medication) could be professionally compromising. Thus, the non-direct, hypothetical nature of a story-stem was deemed appropriate over traditional qualitative methods to provide participants with more freedom to openly express themselves. Due to the novelty of story completion, this method can often produce more in-depth responses from participants. The stimulus (the story stem) does not have a clear objective response, which can eliminate demand characteristics that have been raised as limitations of prior qualitative research in this area. Story completion methods are an ideal tool for researching topics where clear social norms dictate acceptable responses, beliefs or behaviours. This makes it an appropriate method for healthcare professionals who may feel pressure to respond in line with their professional values in a traditional qualitative research format (Clarke et al., 2017).

Participants

Healthcare professionals (medical doctors, surgeons, nurses and allied health professionals) in any field of medicine were recruited using social media (LinkedIn, Twitter, Facebook), the researchers' networks, and snowball sampling to extend recruitment reach. Participants were included if they were currently working as a healthcare professional, recently retired or a

current trainee. Participants were included from any country who spoke sufficient English to complete the task. Towards the end of data collection, targeted recruitment was used to attract a broader demographic of participants. Recommended sample size for story completion studies is 30–60 participants dependent on the richness of data (Braun and Clarke, 2013).

Story completion method and materials

Whilst story completion typically involves the completion of a third-person story (Clarke et al., 2015; Hayfield and Wood, 2019), the current study used a single first-person story stem to investigate the participant's own anticipated response to the given situation, which has previously been used effectively in young people's constructions of their future living with chronic pain (Jones et al., 2020).

The story stem participants received was:

> *You have recently accepted a promotion in your field and as a result have been under a great deal of stress at work, working much longer hours. Recently you have begun to experience intense chest pain, which is gradually becoming more and more painful. What do you think you would do next in this story?*

This story stem was chosen as it focuses on unexplained physical symptoms resulting from a stressful situation, leaving context sufficiently open for participants' own interpretations. It was considered relevant across gender, age, cultures and professions. A minimum length of 900 characters was set to ensure data were sufficiently rich for analysis (Jones et al., 2020). Participants were asked to spend around 15–20 minutes writing the story and told to complete it any way they chose.

Process

Participants were invited to take part via a direct link to the survey on Qualtrics. The online survey provided information about the study and an online consent form. Consent was required before participants were able to continue to the survey questions. Participants completed brief demographic questions and a participant code was requested, which participants could use if they wished to withdraw their data. Participants were then provided with story completion instructions and the story stem. Upon completion, a final screen provided debrief information, including details of who to contact should participants wish to withdraw their data, and thanked them for their participation in the study.

Ethics approval was granted by University of the West of England Psychology Ethics Committee (ref: SJUG20212203).

Analysis

An inductive (data-driven) approach to analysis was used. Data were analysed by the first author in discussion with the second author from a critical realist perspective. This was chosen to legitimise the realities of participants, whilst acknowledging these realities are informed by cultural and societal influences (Lawani, 2021). Data were analysed using Reflexive Thematic Analysis (Braun and Clarke, 2021b) according to Braun and Clarke's six steps:

1. Data familiarisation: The first author copied the Qualtrics data onto a Microsoft Word document and read it over several times to familiarise herself with the responses. Whilst reading, she highlighted and noted down information of interest.
2. Coding: Code labels were applied to all data via pen and paper. Coding was mainly semantic (focusing on participants' explicit meaning), and on some occasions latent (focusing on participants' implicit meaning).
3. Generating initial themes: Codes were reviewed to identify patterns, noting down some candidate theme names and related quotes.
4. 4: Developing and reviewing themes: Tallies were made of how often the theme was identified in the data to ensure the themes were not too 'thin'

lacking a body of evidence (Braun and Clarke, 2013). To aid with this, mini presentations were run on the themes to identify any that could not be talked about for a sufficient duration of time. Thematic maps were also utilised to explore the relationships between the themes and codes (Braun and Clarke, 2006).

5. Refining, defining and naming: Candidate themes were reviewed to ensure they portrayed a convincing story, a brief description was curated to ensure the themes had a solid central organising concept and weren't too broad or overlapping.
6. Writing up: This final step enabled scrutiny of themes to ensure an analytic narrative faithful to the data. During the write up, theme names were further tweaked to reflect the content more accurately, evidencing an ongoing analytic process.

Results

Participants

Forty-four healthcare professionals finished the story completion task. The majority of participants were female (73%), nurses (34%) and white (93%), with a mean age of 48.2 years (standard deviation: 13.7). Participants job titles have been clustered into broad categories (e.g. nurse, doctor) to preserve anonymity (Table 1).

Themes

Three themes were constructed from the data; 'Do I cry or just carry on': A Culture of Suffering in Silence; 'Me? Have a panic attack?': Psychosomatic Shame; and 'We definitely don't take care of ourselves': Prioritising Pressures of Multiple Responsibilities over Self-care. The following presented themes reflect the responses across all participants. Given the open-ended nature of the methodology not all participants' narratives included all issues raised within the themes, but there were no noticeable outlier responses (e.g. narratives that indicated participants would adopt a 'by the book' response to the hypothetical scenario).

'Do I cry or just carry on': A culture of suffering in silence. Healthcare professionals in this study implied there is a peer and institutional culture of suffering in silence within the healthcare workplace in relation to discussing health issues. Participants expressed concerns about burdening colleagues or being seen as 'weak'. Some participants indicated they would choose self-diagnosis or self-medication over discussing their health, whilst others used corridor conversations to avoid formal routes to medical help-seeking.

Responses indicate participants appraise talking to colleagues about their health as a sign of weakness, and it seems particularly important to maintain an image of being strong, competent and able to cope:

> *I would continue to ignore [the pain]. I certainly would not tell anyone. . . can't be seen to fail. (Evelyn, Retired)*

Participants acknowledged that everyone working as a healthcare professional experiences stress, and therefore did not want to burden their colleagues. Participants allude to an implicit expectation of healthcare professionals to keep going, with an implied duty to support an already stretched system:

> *I am beyond hideously exhausted and stressed at the moment but keep carrying on because I work in the NHS and that's what we do. (Margot, Physician Associate)*

Participants indicate this expectation is not simply a pressure they put onto themselves, or a peer culture, but also comes from their experiences with management. The healthcare professionals in this study demonstrate an awareness of the correct 'processes' for reporting health concerns but demonstrate a lack of trust in the

Table 1. Demographic data according to gender.

Variable	Male participants	Female participants	Total participants
	n = 12	*n* = 32	*n* = 44
Age, years			
Mean (SD)	52.1 (11.6)	46.6 (14.3)	48.2 (13.7)
Range	24–64	20–65	20–65
Job title			
Nurse or midwife	0 (0%)	17 (53.1%)	17 (38.6%)
Doctor	9 (75%)	2 (6.3%)	10 (22.7%)
Physician associate/assistant practitioner	1 (8.3%)	3 (9.4%)	4 (9.1%)
Support worker/care assistant	1 (8.3%)	2 (6.3%)	3 (6.8%)
Physiotherapist	0 (0%)	2 (6.3%)	2 (4.5%)
Pharmacist	1 (8.3%)	1 (3.1%)	2 (4.5%)
Podiatrist	0 (0%)	1 (3.1%)	1 (2.3%)
Student nurse	0 (0%)	1 (3.1%)	1 (2.3%)
Healthcare manager	0 (0%)	1 (3.1%)	1 (2.3%)
Retired (1 doctor, 1 previous occupation not given)	0 (0%)	2 (6.3%)	2 (4.5%)
Ethnic background			
White (British/English)	11 (91.7%)	29 (90.6%)	40 (90.9%)
White European	0 (0%)	1 (3.1%)	1 (2.3%)
Bangladeshi	0 (0%)	1 (3.1%)	1 (2.3%)
Indian	1 (8.3%)	1 (3.1%)	2 (4.5%)
Country of residence			
UK	11 (91.7%)	30 (93.8%)	41 (93.2%)
Spain (Catalan)	1 (8.3%)	0 (0%)	1 (2.3%)
India	0 (0%)	1 (3.1%)	1 (2.3%)
New Zealand	0 (0%)	1 (3.1%)	1 (2.3%)
Highest level of education			
Secondary	1 (8.3%)	0 (0%)	1 (2.3%)
College/sixth form	0 (0%)	5 (15.6%)	5 (11.4%)
Degree	4 (33.3%)	13 (40.6%)	17 (38.6%)
Post-graduate study	5 (41.7%)	11 (34.4%)	16 (36.4%)
Doctoral study	2 (16.7%)	1 (3.1%)	3 (6.8%)
Prefer not to say	0 (0%)	2 (6.3%)	2 (4.5%)
Health conditions			
Physical health condition/s	2 (16.7%)	9 (28.1%)	11 (25%)
Mental health condition/s	0 (0%)	1 (3.1%)	1 (2.3%)
Both	0 (0%)	1 (3.1%)	1 (2.3%)
Yes (not specified)	0 (0%)	4 (12.5%)	4 (9.1%)
None	10 (83.3%)	17 (53.1%)	27 (61.4%)

value of this, suggesting that often asking management for support makes no difference:

> *It would probably be a suggestion to speak to my line manager and step down from some of my duties however, that is easier said than done depending on who my line manager is and believe me for a caring profession I have encountered non-caring managers. (Laura, Nurse)*

> *The NHS is relentless and if you are good and have a conscience it will bleed you dry. . .I would*

like to think/hope that my friends and team would notice me struggling and reach out but some colleagues do apply blinkers and the higher tiers above often are not in touch and too distant. As long as you are functioning in the role push on and they would probably give me more for my already rammed workload! (Dawn, Nurse)

Participants also highlighted a lack of support for psychological or mental health issues, even in NHS Trusts that pride themselves on their wellbeing support:

Having had experience of counselling and a period of sick leave due to clinical depression I am afraid I would not entertain seeking help from within my organisation. The organisation prides themselves as being a 'well-being' trust my experience is not so. (Frans, Physician Associate)

Many participants articulated a lack of trusted support at managerial level and in the support offered by the organisation with concerns of their health impacting future job opportunities:

I might speak to my boss. . .although I am saying this in this essay I would actually rather stick pins under my nails than admit I was struggling to my bosses. (Margot, Physician Associate)

Participants also expressed concerns over the confidentiality of their information in management's hands, further contributing to a culture of silence:

I would much prefer to go to my GP for help than any organisation set up by my employer. . .this is because I feel it would be more confidential and I would not need to tell my employer about my condition unless I really needed to. . . and I feel awful actually saying this but I wouldn't trust that the information wouldn't have an affect on any future career aspirations. (Aahana, Nurse)

To avoid seeking either formal or informal treatment or advice participants reported anticipating they would use self-diagnosis, self-treatment or self-medication:

I may initially try to self-medicate. (Anwar, Doctor)

If they [symptoms] continued and don't go away when in work I'd get hold of equipment to see what my blood pressure is etc, self-diagnosis, always the first port of call for someone in healthcare! (Laura, Nurse)

However, some participants did indicate they would use 'corridor conversations' to discuss their health with trusted colleagues if this enabled them to avoid seeking medical help through formal channels such as their GP. Several participants explained that their own doctor simply doesn't know them, or they could anticipate what their GP would tell them. It is also far quicker to receive advice via corridor consultations than a GP appointment, with some participants mentioning current difficulties accessing GP services:

By going into work I would have access to being able to have a quiet word with one of my trusted and very knowledgeable medical colleagues. I'd ask their advice see if they could maybe do a small medical MOT before I speak to my own doctors, if needed. I value their opinions much more than any other doctor as my doctors don't know me; with present circumstances it's been very hard to get hold of my own GP, so I personally feel it's a waste of time. (Carlijn, Support Worker)

In summary, participants described a culture of silence. Responses suggest healthcare professionals do not feel comfortable expressing stress to colleagues or management unless they are seeking corridor consultations to avoid formal avenues to medical support. In this hypothetical scenario, participants anticipated self-medicating or self-diagnosing in response to chest pain. Participants report a lack of trust in management to provide adequate support or for their information to be kept confidential, with fears that their career will be affected. Participants allude to inherent cultural issues within the NHS with an expectation to keep going despite their own health concerns.

'Me? Have a panic attack?': Psychosomatic shame. The hypothetical scenario in the story completion task included a significant physical symptom (increasingly painful chest pain), yet

many participants reported that determining whether they assessed the cause of this hypothetical chest pain as physical or psychosomatic due to stress was important for how they would deal with it:

> *I'd also try to ascertain if it's a psychosomatic stress thing. (Margot, Physician Associate)*

> *I would probably try and determine if this was cardiac in origin myself and ignore it for a while. (Michael, Doctor)*

Participants' story completions included an element of shame and embarrassment being associated with stress manifesting as physical symptoms. Although participants acknowledged psychosomatic symptoms as valid, they were reluctant to accept the possibility of experiencing it themselves:

> *I would be very embarrassed if this turned out to be a psychosomatic episode, but I am aware that this does happen and is a very real phenomenon. (Flynn, Doctor)*

> *Deny there is anything wrong in the first place, would not admit to stress related to start with. (Eleanor, Healthcare Manager)*

This shame and stigma associated with stress related illness was highlighted as a barrier to seeking medical help for symptoms that might have a psychosomatic cause, including a reluctance to accept treatment for issues related to mental health:

> *May think about booking an appointment with the GP perhaps get an ECG but I can't risk being told my symptoms are a sign of stress. . . I don't do stress. (Evelyn, Retired)*

> *I would be worried about any potential stigma if I sought help and was found to have psychogenic symptoms. . . I would be reluctant to have any treatment based on the underlying mental health condition that appears to be the cause of the symptoms. (Luke, Doctor)*

Responses indicated that experiencing physical expressions of stress may challenge a self-identity of being capable, calm and competent and raised concerns about how others would perceive them:

> *The worst part was just how embarrassed I felt in front of all my work mates – making a scene. . . A panic attack? Me? Have a panic attack? No. That can't be right. . . I've never had one before? I'm a fantastic worker, one of the best, that's why I secured that promotion. (Adam, Pharmacist)*

> *My own expectations would be a problem and not wanting to be perceived as a failure and not able to cope in my new role. . . As the promotion was a recent thing I would feel a real pressure to continue and 'man up'. (Dawn, Nurse)*

These data suggest healthcare professionals would worry about the long-term consequences of a stress-related illness, with participants suggesting there is limited institutional support for psychological issues, and either perceived or real expectations to cope with pressure to retain their roles:

> *I feel there is very limited use for occupational health departments. Especially for stress related conditions. (Aahana, Staff Nurse)*

> *If it is stress related the risk is that I would go off sick. Ultimately, I would probably move on from the job, as support through ill health may not be forthcoming and it is often felt that if you can't manage the workload, you shouldn't be doing it. (Laura, Nurse)*

In summary, participants were concerned with identifying whether the hypothetical chest pain in this scenario was physical or psychosomatic. Shame, stigma, and embarrassment were associated with psychosomatic pain with participants reporting being less likely to seek help for pain evaluated as psychosomatic. Participants also indicate worries about colleagues' perceptions and the implications on their suitability for their role of experiencing symptoms caused by stress.

'We definitely don't take care of ourselves': Prioritising pressures of multiple responsibilities over self-care. Many participants noted their lack of self-care and often prioritised their responsibility to others as a healthcare professional. Participants were often open about not prioritising their health due to high workload and increasing demands of their role. Participants' story completions included downplaying or rationalising their symptoms due to other competing demands taking priority:

> *Of course, it is nothing, imagination, bit of stress, nothing to worry about. The thing to worry about is the prep for the corporate governance meeting, analysis, money pots, staffing, risk, the list is endless. (Georgina, Doctor)*

In addition to the specific demands of their healthcare professional role, participants prioritised their family responsibilities over their own health with financial responsibilities in their personal lives also contributing to the prioritisation of work over their own health:

> *Deep down at the back of my mind I would be thinking. . . this could be serious. But Mortgage to pay. . . children to support so ignore those thoughts and carry on. . . In the early hours of the morning I would lie awake thinking of my family history of heart disease. (Evelyn, Retired)*

As might be expected from healthcare professionals, participants were aware of changes in behaviour they could make to protect their health, and the consequences within this hypothetical scenario of not making lifestyle changes. However, they still noted they were unlikely to make these changes:

> *The sensible thing to do would be to lose weight, drink less and retire next year. In reality I shall probably just carry on until it happens again! (Peter, Doctor)*

> *Despite being 47 I am yet to go for my well man check, which was due when I was 40. . . I would unlikely reduce my workload and I would unlikely take some time off. . . The life expectancy of a surgeon is lower and part of that is probably because our behaviour around health is probably less than ideal. (Michael, Doctor)*

Participants were aware that they would give patients or colleagues different advice to the health behaviour decisions they were likely to make for themselves, and highlighted a culture within healthcare of not looking after their own health:

> *Would be a wakeup call if diagnosed with stress related chest pain, health care is tough, complex and busy but we definitely don't take care of ourselves properly, but would give our team members different advice of self-care. (Eleanor, Healthcare Manager)*

It is notable that participants who raised the possibility of making healthy behaviour changes discussed this in the context of needing to leave or alter their roles, indicating a lack of possibility for self-care in current healthcare roles and culture:

> *The next step would be, depending on the conclusions reached, I would decide how I could change my habits. . .to minimise the damaging factors. That could dramatically change my future live [sic] and. . .may involve a change in career, reinventing yourself and maybe taking the opportunity to redirect your job towards something more suitable for your new lifestyle. (Suraj, Retired Doctor)*

In summary, participants reported ignoring or downplaying their symptoms whilst prioritising work and family commitments over their own health. Participants volunteered various behaviour changes that could be made to improve their health in this hypothetical chest pain scenario. However, they reported being unlikely to make these changes and cited a culture of healthcare professionals neglecting their own health.

Discussion

Healthcare professionals' accounts highlighted a culture of suffering in silence, a tendency to

prioritise pressures of multiple responsibilities over self-care, and concerns about shame and stigma of illnesses triggered by stress. These findings indicate a lack of trust in both management and the overall culture to support them through a period of illness, particularly if this was related to stress or mental health.

Our findings that participants across a range of healthcare professionals report a culture of carrying on, worries about appearing medically competent, using corridor consultations, and concerns about confidentiality support previous research that focused specifically on doctors (Kay et al., 2008; Thompson et al., 2001). This points to a culture of working that affects the whole MDT, and support for this would require a team approach that takes into account underlying cultures, structures, and hierarchies.

Many participants in the current study indicated they would engage in self-treatment for hypothetical chest pain. This aligns with a previous systematic review that found self-treatment and self-medication was a significant issue to physicians and medical students with self-treatment reported as >50% in 76% of the 27 included studies (Montgomery et al., 2011). Previous qualitative work with physicians either previously or currently treated for cancer suggests that some physicians approach their own healthcare as they would the care of their own patients and prefer the convenience and control of caring for themselves over seeking formal care (Fromme et al., 2004). Reasons for self-treatment have also been cited as avoiding the patient role, occupational norms about self-treatment, the pressure to perform at work and the need to keep things within the profession (Montgomery et al., 2011). It is important to highlight that despite the potential dangers of self-treatment and self-medication (Rosvold and Tyssen, 2005), our findings suggest that over a decade later self-treatment is still common practice among not only physicians but also healthcare professionals across the MDT. This indicates ongoing organisational culture and professional norms that contribute to maintaining inappropriate and potentially harmful self-treatment behaviours.

Our findings suggest healthcare professionals prioritise their work or family responsibilities over their own health, which presents a barrier to engaging in help-seeking behaviours. Time pressures have historically been an issue in healthcare professions, which became even more demanding during the Covid-19 pandemic (Fiałek, 2022; Grima et al., 2020) and continue beyond the end of covid restrictions with increasing pressure on NHS services and workforce shortages (O'Dowd, 2022). Lack of time and high workload have been commonly cited as reasons why frontline healthcare professionals are considering leaving the profession (British Medical Association, 2021), highlighting the importance of providing support to staff to rest, recover and recuperate.

The current study suggests there is a culture of shame and stigma surrounding mental illness or stress-induced illness among healthcare professionals. This aligns with findings of mental health stigma contributing to avoiding or delaying help-seeking for mental health concerns in the general population (Schnyder et al., 2017). The healthcare professionals in our study seemed to have an appreciation of mental health problems being legitimate health issues, yet there remained concerns about how they would be perceived or treated by colleagues or management for these. Depression amongst physicians is estimated at over double that of the general population (Mata et al., 2015) and there is an increased risk of suicide amongst those working in healthcare (Office for National Statistics, 2021). This mental health impact worsened during the Covid-19 pandemic with healthcare professionals reporting occupational and psychological pressures associated with working on the frontline (Billings et al., 2021). This impact intensified in the second wave of the pandemic, partly due to the length of time participants had been exposed to these pressures and the lack of time to rest and recuperate (Harris et al., 2021). This cumulative burden of pressure is unlikely to imminently reduce with continually increasing pressures on NHS services and workforce (O'Dowd, 2022). Thus, it would be important to consider appropriate and

effective mental health support for all healthcare professionals, which may be most effective if there is dedicated time protected for regular mental health support without relying on self-referral.

Finally, throughout our findings the concept of identity seems to play a key role with the importance of assuming a healthcare professional identity potentially conflicting with having to assume a role of patient. This healthcare professional identity may also exacerbate feelings of needing to prioritise others over their own health. The negotiation of power between doctors and patients can be difficult (Khazen, 2022), which may go some way to explaining the appeal of corridor conversations where healthcare professionals can maintain an equal dynamic between two peers without having to adopt a patient identity (McKevitt and Morgan, 1997). Further, it is possible the 'superhuman' or 'NHS hero' identity often imposed upon healthcare professionals by the media only further exacerbates self-imposed pressure to go above and beyond potentially to the detriment of their own health and wellbeing (Cox, 2020).

This study may have limitations in missing the voices of healthcare professionals who were unable to find the time to take part in this study. This potential recruitment bias might reduce the likelihood of identifying the experience of healthcare professionals with demanding roles that they prioritise over self-care, which nevertheless was a key theme in this data. This study did not identify any participant narratives that reported swiftly discussing with management and following traditional referral routes. It is possible we are missing the voices of healthcare professionals who hold these views as they may have been less interested in the study topic for participation. We should also consider that the nature of writing a story may discourage narratives being included that could be perceived as 'less interesting'. Story completion methods could be criticised for their hypothetical nature, and not enabling the researcher to follow up on topics of interest in more depth. However, this method enabled the exploration of implicit views and concepts such as self-medication that may be difficult to directly discuss without concerns about compromising professional roles (Clarke et al., 2017). Further, many responses were detailed and in-depth, demonstrating participant engagement with this topic (Braun and Clarke, 2021a). The hypothetical nature of the scenario given to participants means we should be cautious in how we apply this to real world scenarios. Nevertheless, it provides valuable insight into perceived pressures and barriers experienced by healthcare professionals.

This study is also limited by the majority of participants being white, female and nurses, which may not reflect the experiences and views across the healthcare workforce. The majority of participants (93%) are in the UK, indicating there may be a systemic issue to address in UK healthcare. However, although some narratives specifically mention the NHS, we did not ask participants whether they worked in the private or public sector, which would have added useful additional context to these findings. This is the first story completion study to explore healthcare professionals' attitudes to help-seeking for symptoms of a physical illness, and the first qualitative study to focus on this issue in the wider MDT.

These novel data exploring healthcare professionals' anticipated responses to hypothetical symptoms of chest pain have highlighted a pervasive culture of carrying on despite health concerns, prioritising responsibilities over self-care, and self-treatment or treatment through 'corridor conversations'. Participants also raised issues of trusting medical information will be kept confidential, impact of illness on career opportunities, and a perceived stigma of mental health related illnesses. It is likely that effective support for healthcare professionals would need a systemic approach that tackles ingrained cultural norms and barriers. Future research should work with healthcare professionals and management to design and test appropriate and effective support that is realistic to implement in the busy and demanding healthcare environment. It will be important that any support created has transparent processes for ensuring confidentiality, does not

rely on self or manager referral, and that it does not add additional pressures to healthcare professionals' already high workloads.

Author contributions

Caitlin Vries: conceptualisation, data collection, data analysis, writing – original draft. Caroline A Flurey: conceptualisation, writing – reviewing and editing, supervision.

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Data sharing statement

The data underlying this article cannot be shared publicly due to the nature of qualitative data making it possible for participants to be recognised from context through full transcripts. While the sharing of illustrative quotes is covered by participant consent and ethics, the sharing of full transcripts is not.

Declaration of conflicting interests

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Ethics approval

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Informed consent

Participants provided written consent via a tick box form on the online survey.

Pre-registration

N/A

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